

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18247 ✓
State File No. _____
Registrar's No. 92

FILED MAY 18 1944 6
Registration District No. 146

Primary Registration District No. 5568

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Independence, RR 2
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Blue Township
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 8.3 years (years, months or days)

3. (a) PRINT FULL NAME James M. Kimbrell

3. (b) If veteran, _____ 3. (c) Social Security
name war _____ No _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Mr. Mattie Kimbrell 6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased April 22 - 1860
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
83 11 14 hr. min.

9. Birthplace Blue Mills Jackson Co
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Lewis Kimbrell
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Jane Franklin
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Birdie Dorlague
(b) Address R.F.D. # 2 Indef Mo

17. (a) Rural (b) Date thereof April 9-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation See note on page 2

18. (a) Signature of funeral director W. E. Mitchell
(b) Address 310 N. Main Independence Mo.

19. (a) 4-8-1944 (b) James M. Kimbrell
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Independence RR 2
(If outside city or town limits, write "RURAL")
(d) Street No. Blue Township
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 6
year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from February 1944 to April 6 1944
that I last saw him alive on April 6 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia Duration 3 days

Due to Basal cell carcinoma of nape & head
Due to _____

Other conditions.
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature Fred J. Zimmerman (M. D. or other) D.O.
Address Indef. Mo. Date signed 4-8-44

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

48
0
0

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed

Henry G. Mitchell

Licensed Embalmer No.

3925

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above..